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IN THE
Supreme Court of the United States
OCTOBER TERM, 1990

ROCKFORD MEMORIAL CORPORATION and
SWEDISHAMERICAN CORPORATION,
Petitioners,

v.

UNITED STATES OF AMERICA,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

This *amicus curiae* brief is filed on behalf of the American Hospital Association ("AHA") with the written consent of the parties to this action.[1] AHA supports granting certiorari on Question 2 of the petition with respect to the issue of the appropriate product market.

STATEMENT OF INTEREST

The AHA is a not-for-profit membership corporation organized under the laws of the State of Illinois, and is the primary organization of hospitals in the United States. Its membership includes approximately 5,500 hospitals and other health care institutions, as well as approximately 49,000 individuals. The principal corpo-

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[1] *See* Sup. Ct. R. 37.2. Statements of consent are on file with the Clerk of the Court.

rate objective of the AHA is to promote high quality health care and health services for all people through leadership and assistance to hospitals and health care organizations in meeting the health care needs of their communities. AHA's members believe that in appropriate cases mergers and consolidations can reduce hospital costs and benefit the public. At the present time, due to the dramatic changes in the hospital industry, there are increasing numbers of hospital consolidations. AHA's members are all potentially subject to proceedings brought by the Department of Justice or the Federal Trade Commission to challenge such mergers and consolidations under the antitrust laws. The definition of the relevant product market is an important issue in these cases, and the appropriate resolution of that issue is significant to AHA's membership.

REASONS FOR GRANTING THE WRIT

In determining that competing outpatient providers should be excluded from the relevant product market in hospital merger cases as a matter of law, the Seventh Circuit, in an opinion by Judge Posner, has decided an important and recurring question of federal antitrust law in conflict with the decisions of this Court and of other circuits.

I. THE PRODUCT MARKET ISSUE PRESENTED IN THIS CASE IS IMPORTANT AND IS LIKELY TO RECUR IN FUTURE HOSPITAL MERGER CASES.

The health care industry is the single largest sector of the nation's economy. Expenditures on health care approached $600 billion in 1989.[2] Health care services exceed 11% of the Gross National Product, and the proportion of the GNP they represent continues to grow.[3]

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[2] International Trade Admin., U.S. Dep't of Commerce, *1990 U.S. Industrial Outlook* 49-1, 49-1 (1990).

[3] *Id.*

The industry is currently experiencing a crisis due to escalating health care costs.[4] This is one of the key issues affecting the United States today, so significant that President Bush addressed the issue in his State of the Union Address, promising that we are "committed to bringing the staggering costs of health care under control." [5]

This acceleration in health care costs has resulted in significant part from the effect on the health care industry of past policies of the federal government—policies that were designed to increase the availability of health care services to the American public. The federal government is the single largest purchaser of hospital services, accounting for approximately 50% of hospital revenues.[6] Beginning in the middle 1960s, with the adoption of the Medicare and Medicaid programs, and with the expansion of private health insurance coverage, an enormous demand for additional health care services was create to serve those who previously had been unable to afford quality care. At the same time, the federal government encouraged hospitals to construct modern facilities,[7] and indirectly encouraged the construction and

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[4] *See* Burda, *Hospital Closures Top Record at 79—AHA*, Modern Healthcare, Mar. 25, 1988, at 4; Freudenheim, *Rising Number of Hospitals Forced to Close*, N.Y. Times, June 23, 1988, at A17, col. 1.

[5] President's State of the Union Address, 26 Weekly Comp. Pres. Doc. 146, 148 (Feb. 5, 1990).

[6] International Trade Admin., *supra* note 2, at 49-2.

[7] Federal financial assistance was provided under the Hill-Burton Act, 42 U.S.C. § 291 (1982), to assist in the construction and modernization of hospitals in return for a commitment to provide care to indigent patients. *See American Hosp. Ass'n v. Schweiker*, 721 F.2d 170, 172-73 (7th Cir. 1983), *cert. denied sub nom. American Hosp. Ass'n v. Heckler*, 466 U.S. 958 (1984). Approximately 6,900 facilities received Hill-Burton assistance, a substantial number of which were acute care hospitals. Office of Health Facilities, U.S. Dep't of Health & Human Services, *Directory of*

staffing of such facilities by providing reimbursement to hospitals on a cost reimbursement basis.[8] The cost reimbursement approach encouraged individuals to seek, and hospitals to provide, the best available health care, regardless of cost. As a result of all of these factors, hospitals invested in the construction of costly facilities, physical plants, equipment, and the staffs to operate them.

In 1983, however, the federal government, in response to rising health care costs, changed its policies and revised its method for paying hospitals for treating Medicare patients. The federal government now pays a set amount for each patient based on a particular diagnosis, which constrains hospitals' investments in costly services and equipment. 42 U.S.C. § 1395ww (1982 & Supp. VI 1986). The federal government establishes rates for Medicare reimbursement that are often below the fully allocated costs of the services provided. Furthermore, Medicare capital payments to hospitals have been reduced by 15% for rural and urban hospitals,[9] and an additional 10% reduction for urban hospitals has been proposed.[10] Similarly, state governments and private payers are eliminating cost-reimbursement arrangements and have sought to establish fixed fees for hospital services, forcing hospitals to bear the burden of rising costs that exceed the amount of reimbursement.[11]

Facilities Obligated to Provide Uncompensated Services by State and City as of January 1, 1986, 187 (1986).

[8] *See* S. Rep. No. 23, 98th Cong., 1st Sess. 47 (1983).

[9] Omnibus Budget Reconciliation Act of 1989, P.L. No. 101-239, § 6002, 103 Stat. 2106, 2140 (1989).

[10] U.S. Dep't of Health and Human Services, *The Fiscal Year 1991 Budget* 46-47 (1990).

[11] *See* Guterman & Dobson, *Impact of the Medicare Prospective Payment System for Hospitals*, 7 Health Care Financing Rev. 97, 106 (1986).

These fixed fee arrangements have been effective in constraining costs to purchasers of health care services because of the enormous power that the federal and state governments and large private insurers enjoy in the health care industry. Hospitals by and large must accept the fixed fees established by the federal government because they are unable to survive without Medicare business, which constitutes, on average, 40% of a hospital's revenue.[12] Similarly, state governments and large private insurers, which also account for a signifiant portion of hospital revenues, are able to negotiate low fixed prices because their business is essential to most hospitals.[13] As a consequence, hospitals do not, for the most part, have the ability to control the prices they are paid.

These cost-containment measures have led to a decline in both admissions to hospitals and the length of hospital stays.[14] Hospital occupancy has therefore fallen dramatically.[15] Between 1980 and 1986, occupancy rates fell from 75.9% to 63.4%.[16]

This trend has been exacerbated by the shift of patients out of the hospital to providers of outpatient services, a trend encouraged by the federal government and other major purchasers of health care services such as state governments, commercial insurers, and self-insured employers. Outpatient visits to hospitals have increased by 160% since 1980; indeed, according to the latest data,

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[12] American Hosp. Ass'n, *Hospital Statistics—Data from the American Hospital Association 1988 Annual Survey* xxxiii (1989).

[13] Overall, private third-party payers account for 35% of hospital revenues. *Id.*

[14] Hellinger, *Recent Evidence on Case-Based Systems for Setting Hospital Rates*, 22 Inquiry 78, 85 (1985); Guterman & Dobson, *supra* note 11, at 103-04, 109.

[15] Bureau of the Census, U.S. Dep't of Commerce, *Statistical Abstract of the U.S. 1989*, at 102 (1989).

[16] American Hosp. Ass'n, *Economic Trends* 4 (1990).

since 1986 outpatient visits have exceeded inpatient days.[17] Almost half of all surgical procedures are now outpatient procedures,[18] and growth in outpatient revenues far outstrips growth in inpatient revenues.[19] As the district court in this case recognized, "many types of traditionally inpatient care and treatment, including many diagnostic tests and types of surgery, [are now being] performed on an outpatient basis." Pet. App. at a-162-a-163.[20] The district court also explained that "[t]his trend has caused the number of inpatient days at hospitals to level out and in some cases drop." Pet. App. at a-163.

While revenues have been decreasing as a result of cost-containment measures and competition from outpatient providers, hospitals continue to bear the burden of costly investments encouraged by earlier federal policies, and hospital operating costs continue to rise. Overall, costs to hospitals have increased almost 30% since 1984, while the Medicare update factor, which was originally intended to compensate for the effect of inflation, has increased only 16%.[21] This is particularly troublesome when Medicare accounts for, on average, 40% of a hospital's revenue.[22]

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[17] American Hosp. Ass'n, *supra* note 12, at xxv.

[18] American Hosp. Ass'n, *Annual Survey of Hospitals* (1988).

[19] From 1984 to 1989, inpatient revenue rose on average only 6.5% per year while outpatient revenues grew more than 16%. Prospective Payment Assessment Commission, *Medicare Prospective Payment and the American Health Care System: Report to the Congress* 52 (1990).

[20] Cites to "Pet. App." are to the Appendix to the Petition for Writ of Certiorari in this case. *See also* Noether, *Competition Among Hospitals*, 7 J. Health Econ. 259, 279 (1988).

[21] Statistical Information Compiled by the Office of Health Fin. & Data Analysis, American Hosp. Ass'n (1990) (numbers include 1990 projections).

[22] American Hosp. Ass'n, *supra* note 12, at xxxiii.

Thus, hospital operating margins have drastically declined. The Deputy Administrator of the Medicare program has acknowledged the problem, stating that "[a] significant proportion of hospitals will experience losses on their Medicare business" and that hospital profit margins are "close to zero."[23] Hospitals have been forced to cut back their operations, sometimes at the expense of more innovative programs and services. Those hospitals that have been unable to contain their increasing costs are in serious financial difficulties.[24] These financial troubles have caused many hospitals to seek to merge with stronger facilities or, when unable to merge, even to close their doors.[25]

Consolidation can enable two hospitals to utilize their fixed-cost assets more productively. For example, total costs can be lowered if one of the consolidating hospitals transfers its obstetrical and pediatric services to the other hospital, and the second shifts its cardiac surgery program to the first. Hospital mergers often achieve scale economies and create more efficient facilities that are better equipped to operate under the new reimbursement schemes.[26] When a weak hospital is rescued by a stronger hospital, access to health care services that might other-

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[23] Freudenheim, *supra* note 4, at A17, col. 1.

[24] *See* Office of Evaluation and Inspections, Office of Inspector Gen., U.S. Dep't of Health & Human Services, *Hospital Closure: 1988*, at 8 (1990).

[25] *Id.* at 7; *see also* Burda, *supra* note 4, at 4. In 1982, only 23 hospitals closed; in contrast, in 1987, 79 hospitals closed and in 1989, 80 hospitals closed. Hospital Data Center, American Hosp. Ass'n, *Hospital Closures 1980-89: A Statistical Profile* 6 (1990).

[26] *See* Blackstone & Fuhr, *Hospital Mergers and Antitrust: An Economic Analysis*, 14 J. Health Pol., Pol'y & L. 383, 383 (1989); Carr & Feldstein, *The Relationship of Cost to Hospital Care*, 4 Inquiry 45, 63 (1987); *see generally* Cohen, *Variations in Cost Among Hospitals of Different Sizes*, 33 S. Econ. J. 355 (1967).

wise have become unavailable can be preserved, thus benefiting consumers.[27]

Not surprisingly, in light of these advantages of mergers, the hospital industry is going through a period of consolidation. In 1987 there were almost twice as many hospital mergers as in 1982, and that trend is continuing.[28] At the same time, hospitals attempting to consolidate have been challenged with increasing frequency by the Department of Justice and the Federal Trade Commission. These agencies, while at times recognizing the benefits of hospital mergers, have displayed considerably less enthusiasm for this solution to the predicament of the hospital industry. Almost as many cases were filed in the past two years of the decade as were brought in the preceding eight.[29] Recent statements by the enforcement agencies indicate that hospital mergers will continue to be a priority of both the Department of Justice and the

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[27] *See* R. Posner, *Antitrust Law—An Economic Perspective* 96 (1976) (anti-merger laws are costly because, among other reasons, mergers that may be held to violate the antitrust laws may serve to exploit economies of scale).

[28] Burke, *Mixed Signals from Government Have Chilling Effect on Mergers*, Hospitals, June 5, 1990, at 36.

[29] Five actions were brought from 1980 to 1987. *United States v. National Medical Enterprises*, 1987-1 Trade Cas. (CCH) ¶ 67,640 (E.D. Cal. June 25, 1987) (consent decree); *United States v. Hospital Affiliates Int'l*, 1980-81 Trade Cas. (CCH) ¶ 63,721 (E.D. La. Oct. 9, 1980); *Hospital Corp. of America*, 106 F.T.C. 361 (1985), *aff'd sub nom. Hospital Corp. of America v. FTC*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987); *Hospital Corp. of America* (*In Re* Forum), 106 F.T.C. 298 (1985) (consent order); *American Medical Int'l*, 104 F.T.C. 1 (1984). Since June 1988, four additional cases have been filed, including this one: *United States v. Rockford Memorial Corp.*, Pet. App. a-1 - b-46; *United States v. Carilion Health Sys.*, 707 F. Supp. 840 (W.D. Va.), *aff'd*, 892 F.2d 1042 (4th Cir. 1989) (unpublished); *Reading Hosp.*, 55 Fed. Reg. 15,290 (FTC 1990) (consent order); *Adventist Health System/West*, 5 Trade Reg. Rep. (CCH) ¶ 22,761 (FTC Nov. 7, 1989) (FTC complaint).

Federal Trade Commission.[30] Thus, a significant number of hospital merger actions are likely to be brought in the future.

Defining the relevant market is the first step in determining whether any merger violates the antitrust laws,[31] and market definition is frequently the determinative factor as to the lawfulness of a particular merger.[32] The government's own guidelines for analyzing horizontal mergers state that "[m]arket definition has historically played a crucial role in antitrist analysis. . . ." U.S. Dep't of Justice Revision of 1982 Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13,103, at 20,551 (June 4, 1984).[33]

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[30] J. Steiger, Chairman of the FTC, Remarks at the Legal Seminar for Nonprofit Organizations 6-7 (June 28, 1990); M. Horoschak, Assistant Director for Health Care, Bureau of Competition, Materials Accompanying Remarks at Nat'l Health Lawyers Ass'n Seminar, Antitrust in the Health Care Field 26 (Feb. 16, 1990); R. Bloch, Chief of Professions and Intellectual Property Section, Antitrust Div., Dep't of Justice, Remarks at the New England Antitrust Conference 2 (Nov. 4, 1989).

[31] *See Brown Shoe Co. v. United States*, 370 U.S. 294, 324 (1962); *United States v. E.I. du Pont de Nemours & Co.* 353 U.S. 586, 593 (1957).

[32] *See, e.g., United States v. Continental Can Co.*, 378 U.S. 441, 458-61 (1964); *Kaiser Aluminum & Chem. Co. v. FTC*, 652 F.2d 1324, 1329-30, 1341 (7th Cir. 1981); *see also* Baker, *The Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, 51 Law & Contemp. Probs. 93, 119 (1988) ("Market definition is often the determinative analytic step in antitrust litigation, and thus is strongly contested."). Product market definition can be important in other types ofantitrust cases as well, and principles established in merger cases can affect market definition in conduct cases. *See* 2 P. Areeda & D. Turner, *Antitrust Law—An Analysis of Antitrust Principles and Their Application* 321 (1978); L. Sullivan, *Handbook of the Law of Antitrust* 605 (1977); *compare United States v. Philadelphia Nat'l Bank*, 374 U.S. 321 (1963) (cluster market approach applied in merger case) *with United States v. Grinnell Corp.*, 384 U.S. 563 (1966) (cluster market approach applied in monopolization case).

[33] *See also* FTC Statement Concerning Horizontal Mergers, 4 Trade Reg. Rep. (CCH) ¶ 13,200, at 20,905 (June 4, 1984) ("is-

As Judge Posner himself has written in his antitrust treatise, "[t]he definition of the market in which to measure the market shares of the merging parties and their competitiors is critical; given enough flexibility in market definition a surprising number of innocuous mergers can be made to appear dangerously monopolistic." R. Posner, *supra*, note 27, at 125.

Not surprisingly, in virtually every litigated hospital merger case, the product market question was hotly contested, and the parties raised the same issues of market definition as are presented in this case. The question of the appropriate product market definition that should be applied to the unique facts of the hospital industry has divided not only the Antitrust Division, private litigants, and the courts,[34] but commentators as well.[35]

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sues of market definition are critcally important to sound merger analysis.").

[34] *Compare, e.g., Rockford Memorial Corp.*, Pet. App. at b-31-b-34 (excluding outpatient providers) *with Carilion Health Sys.*, Pet. App. at d-38 (including outpatient providers). The product market issue has led to varying approaches at the Federal Trade Commission. For example, *American Medical Int'l*, 104 F.T.C. at 192-93, defined the relevant product market as "general acute care hospital services," a market definition that included outpatient services provided by hospitals, but not those provided by non-hospital providers. *Hospital Corp. of America*, 106 F.T.C. at 466, defined the market as "general acute care hospital services" but stated that the market must be viewed "with primary reference to the cluster of services provided to inpatients." *See* Comment, *Defining the Relevant Market in Health Care Antitrust Litigation: Hospital Mergers*, 75 Ky. L. J. 175, 199 (1987) (difference in product market definition between the *American Medical Int'l* and *Hospital Corp. of America* cases could be significant in future cases).

[35] *Compare* Cruz, *Product and Geographical Market Measurement in the Merger of Hospitals*, 91 Dick. L. Rev. 497, 514 (1986) ("non-hospital providers should be considered competitors of hospitals and their services should be included in the product market") *with* Comment, *supra* note 34, at 194 ("Defining the relevant market as inpatient hospital services . . . is appropriate for

At the present time, varying definitions of the product market in hospital merger cases have caused substantial confusion in the industry, which finds it difficult to assess whether planned consolidations are likely to pass muster under the antitrust laws.[36] Resolution of this important question under the appropriate standard is critical to the industry, and indeed to all parties in pending and future cases involving hospital mergers.

II. IN TREATING THE PROPER DEFINITION OF THE PRODUCT MARKET AS A QUESTION OF LAW RATHER THAN OF FACT, THE SEVENTH CIRCUIT HAS DECIDED AN IMPORTANT QUESTION OF ANTITRUST LAW IN CONFLICT WITH THE DECISIONS OF THIS COURT AND OTHER CIRCUITS.

The hospital industry, of course, does not seek to be treated differently than other industries for purposes of product market definition. However, in this case, the Seventh Circuit has departed from the existing approach and treated the question of appropriate market definition as a question of law rather than as a question of fact. In so doing the Seventh Circuit has rendered a decision that is in conflict with decisions of this Court and of other circuits, and particularly with the decision of the Fourth Circuit in *United States v. Carilion Health Sys.*, 892 F.2d 1042 (4th Cir. 1989) (unpublished), which held in a similar hospital merger case that the product market was an issue of fact and affirmed a district court finding that non-hospital providers should be included in the market.

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the health care industry."); *see also* Baker, *supra note* 32, at 126 (a narrow definition of product market "may lead courts to underestimate the significance of outpatient clinics in restraining some forms of hospital collusion, and so to interdict mergers generating increased concentration among hospitals when the danger of collusion is limited.").

[36] *See* Leonard & Rosch, *Courts Split on Clayton Act Use in Non-Profit Hospital Mergers*, The Nat'l L. J., Nov. 27, 1989, at 18, 19.

As in most hospital merger cases, the parties in the present case differed sharply as to the appropriate product market. The Antitrust Division urged that the product market should be limited to inpatient services provided by hospitals. *See* Brief for Appellee United States at 8-12, *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990) (No. 89-1900). The merging hospitals, petitioners in this Court, urged that the market should include outpatient services offered by non-hospital providers (providers whose competition, in part, had contributed significantly to the conditions necessitating hospital mergers in the first place). *See* Brief of Appellants Rockford Memorial Corp. and SwedishAmerican Corp. at 14, *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990) (No. 89-1900).

The district court adopted the government's position, finding that the relevant product market consisted of a cluster of services offered only by acute care hospitals. It excluded services offered by other types of facilities, even those offered by outpatient facilities that, as the district court recognized, compete directly with acute care hospitals.[37]

On appeal, petitioners challenged the district court's conclusions on a number of grounds. Pointing out that this Court's precedents demonstrate it is not necessary that there be a complete overlap between competing products in order for them to be included in the same market,[38] petitioners urged that the appropriate test was reasonable substitutability and that "[t]he record in this case . . . establishes that outpatient care is a functional

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[37] "It is true, as the defendants contend, that non-hospital providers such as out-patient clinics, emergency care centers, doctors offices and other providers, offer some of the same services as do acute care hospitals." Pet. App. at a-52.

[38] Appellants' Brief at 15; *see United States v. Connecticut Nat'l Bank*, 418 U.S. 656, 662 (1974); *Continental Can Co.*, 378 U.S. at 455-57.

substitute for a significant and growing amount of inpatient care. . . ." Appellants' Brief at 15. Petitioners argued that the district court's findings were "clearly erroneous" because there was "extensive evidence of substitutability and actual substitution," Appellants' Brief at 22; Reply Brief of Appellants Rockford Memorial Corp. and SwedishAmerican Corp. at 6, *United States v. Rockford Memorial Corp.*, 898 F.2d 1278 (7th Cir. 1990) (No. 89-1900), and contended that the trend towards increasing utilization of outpatient facilities should have been considered by the district court, Appellants' Brief at 18; *see United States v. General Dynamics Corp.* 415 U.S. 486, 501 (1974). Petitioners also asserted that the district court did not take into account the effect of the presence of large third-party payers on the extent of competition between hospitals and outpatient providers. *See* Appellants' Brief at 18.[39]

The Antitrust Division, in contrast, urged that the district court's findings should be sustained because "[t]he key question is whether buyers today would substitute outpatient services for inpatient services if the defendants imposed a price increase, and the answer, as the district court found, is clearly that they would not do so." Appellee's Brief at 11-12.

The Seventh Circuit affirmed the district court's decision, rejecting petitioners' claim that outpatient providers should have been included. Pet. App. at b-31-b-34. But in doing so it failed to address petitioners' objections to the district court's factual findings. Instead, it adopted an approach entirely at odds with that of the district court or either of the parties in this case. Rather than reviewing the factual findings of the district court and basing its decision on the factual record, the Seventh Circuit approached the issue of product market definition

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[39] The district court made no findings with respect to the effect of large payers on competition in the health care industry. *See* Pet. App. at a-213-a-286.

as a matter of law, relying on its own intuition and unsupported opinions about characteristics of the hospital industry. In effect, the Seventh Circuit enunciated a new, inflexible rule of law, applicable to all hospital merger cases, that the relevant product market cannot include providers of outpatient services.[40]

The Seventh Circuit's approach is contrary to this Court's decisions. This Court has established that the question of product market definition is one of fact, not of law, and has enumerated the factors that should be considered in determining the product market for antitrust analysis. Courts should determine "the reasonable interchangeability of use . . . between the product itself and substitutes for it" by examining "such practical indicia as industry or public recognition of the [market] as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors." *Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962). These factors must be given "careful consideration based upon the entire record." *Continental Can Co.*, 378 U.S. at 449.[41]

This Court's decisions also require a thorough analysis of the specific conditions of the industry at issue when defining a relevant product market. For example, in *Philadelphia Nat'l Bank*, 374 U.S. at 356-57, the case in which this Court first enunciated the "cluster market" approach used in hospital merger cases, *see* Pet. App. at a-75; *Hospital Corp. of America*, 106 F.T.C. at 436, 466, the Court examined competitive conditions in the banking in-

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[40] Pet. App. at b-31-b-34. It is particularly ironic that the court excluded outpatient services from the relevant market, given that the shift of patients to outpatient providers is one of the major reasons hospitals are finding it necessary to consolidate. *See supra* pp. 5-6.

[41] *See also Kaiser Aluminum & Chem. Co.*, 652 F.2d at 1329; *Telex Corp. v. International Business Machines*, 510 F.2d 894, 915 (10th Cir.), *cert. dismissed*, 423 U.S. 802 (1975).

dustry to determine which firms should be included in the market. In subsequent bank merger cases, this Court again analyzed the competitive dynamics of the industry to define the relevant market. *Connecticut Nat'l Bank*, 418 U.S. at 663-66; *United States v. Phillipsburg Nat'l Bank & Trust Co.*, 399 U.S. 350, 369-61 (1970).

The Seventh Circuit did not consider the actual facts of this particular industry and ignored virtually all of the *Brown Shoe* factors in its brief discussion of the product market issue. Indeed, the opinion did not even trouble to cite *Brown Shoe* or any other decision of this Court in its product market discussion, much less apply the analysis required by this Court's decisions. The opinion's disdain for factual analysis is not merely of academic interest. If the Seventh Circuit decision is followed, courts of appeals in future cases will not examine the facts of the marketplace and the dynamics of the industry in product market determinations.

In declining to address petitioners' factual contentions, the court of appeals ignored central factual issues relevant to product market definition. For example, the existence of "distinct customers" and "specialized vendors" in the health care industry has enormous significance. As we have discussed above, the fact that the federal and state governments and large private purchasers account for a substantial portion of hospital revenues, and the critical importance of such purchasers to any hospital, severely constrains the ability of hospitals to raise prices. Those constraints exist not only with respect to the wide range of services that are available outside the hospital context but with respect to the services that are offered only in hospitals. This is so because of the power that the federal government has to refuse to pay excessive prices and the threat that other purchasers will take their outpatient business to non-hospital providers.[42]

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[42] These third-party payers have the power to use the outpatient providers as leverage over hospitals even for inpatient services. If

The only portion of the Seventh Circuit's opinion that appears to follow the *Brown Shoe* approach indeed recognizes the existence of non-hospital competitors. The court of appeals noted that petitioners "point out correctly that a growing number of services provided by acute-care hospitals are also available from non-hospital providers." Pet. App. at b-31. But the court then dismisses them as irrelevant, stating "the force of the point eludes us." *Id.* It is just such cavalier dismissal of the record that this Court has condemned in other antitrust cases. *E.g.*, *Connecticut Nat'l Bank*, 418 U.S. at 665; *Continental Can Co.*, 378 U.S. at 449. In applying its own idiosyncratic views to the product market analysis, the Seventh Circuit has rendered a decision in clear conflict with this Court's requirements.

The decision below also directly conflicts with a ruling of the Fourth Circuit involving a similar hospital merger. *Carilion Health Sys.*, Pet. App. at e-1-e-20. In *Carilion*, the Fourth Circuit decision upheld a district court decision defining the relevant product market to include outpatient providers. Pet. App. at e-16-e-17. The court of appeals in *Carilion* again treated the question as one of fact, upholding the district court's findings as not clearly erroneous. *Id.* The decision in the present case cannot be reconciled with the Fourth Circuit's decision in *Carilion*, either in terms of the approach to product market definition or in the result it reached.[43]

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there is a substantial amount of competition between hospitals and outpatient providers for patients in need of outpatient services, large purchasers can insist on reasonable prices for inpatient services by threatening to channel their subscribers to non-hospital providers for outpatient services.

[43] There is thus a conflict between the decision below and *Carilion* on both the standard (whether the issue is one of law or fact) and the application of the standard to the hospital industry. In view of the size and importance of the hospital industry, we urge that the conflict that exists with respect to application of the standard also warrants review by this Court.

The Seventh Circuit's holding in this case is also contrary to decisions of the Sixth, Ninth, and Tenth Circuits, which have specifically held that product market definition is a question of fact. *United States v. Central State Bank*, 817 F.2d 22, 24 (6th Cir. 1987) ("relevant product market definition" is a question of fact); *Thurman Industries v. Pay 'N Pak Stores*, 875 F.2d 1369, 1374 (9th Cir. 1989) ("For antitrust purposes, defining the product market involves identification of the field of competition . . . . This definitional process is a factual inquiry . . . ."); *Telex Corp.*, 510 F.2d at 915 ("market definition is generally treated as a matter of fact").

In sum, the appropriate approach to product market definition in hospital merger cases is an important and recurring question of federal antitrust law. The decision of the Seventh Circuit is contrary to the decisions of this Court and to the decisions of other courts of appeals. Certiorari should be granted.

CONCLUSION

For these reasons, the Court should grant the Petition for a Writ of Certiorari.

Respectfully submitted,

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